It Starts With Me
Employee Health Screening

Health & Wellness Questionnaire

Printed Name (first, middle initial, last) _____ Address _____

City/State/Zip _____ Telephone Number _____

Date of Birth: ___/___/___ Age:_____ Sex: ❑ Male ❑ Female Employer: _____

Marital Status: ❑ Never Married ❑ Married ❑ Separated ❑ Divorced ❑ Widow/Widower

In relation to the employer which is sponsoring this health screening, I am:
❑ the employee ❑ the spouse of an employee ❑ a dependent of the employee ❑ a retired employee ❑ other

1) Currently, how would you rate your health? ❑ Excellent ❑ Good ❑ Average/Fair ❑ Below Average ❑ Poor

2) In the past 12 months, I have attempted to:
❑ Lose Weight ❑ Decrease cholesterol ❑ Lower blood pressure ❑ Exercise more ❑ Eat a healthier diet ❑ Decrease Stress

3) Do you currently have any of the following health issues?
❑ Arthritis ❑ Asthma ❑ Cirrhosis of the Liver ❑ Diabetes ❑ Heart Disease (angina, coronary artery disease)
❑ Headaches ❑ High Blood Pressure ❑ Lung Disease (Emphysema or Bronchitis) ❑ Osteoporosis ❑ Ulcers

4) PERSONAL MEDICAL HISTORY

Please check those conditions that you have or have ever had.
- ❑ A poisoning in your lifetime requiring medical attention
- ❑ Heart Problems or Condition (Angina or Coronary Artery Disease)
- ❑ High Blood Pressure (Hypertension)
- ❑ High Cholesterol
- ❑ Stroke
- ❑ Colon Cancer
- ❑ Breast Cancer
- ❑ Ovarian or Cervical Cancer
- ❑ Prostate or Testicular Cancer
- ❑ Other type of Cancer
- ❑ Diabetes

5) FAMILY MEDICAL HISTORY

In regard to your immediate family members (siblings, parents, grandparents):
Do they have, or have they had, any of the following? (Check those that apply)
- ❑ Heart Problems or Condition
- ❑ High Blood Pressure (Hypertension)
- ❑ High Cholesterol
- ❑ Stroke
- ❑ Colon Cancer
- ❑ Breast Cancer
- ❑ Ovarian or Cervical Cancer
- ❑ Prostate or Testicular Cancer
- ❑ Other type of Cancer
- ❑ Diabetes

6) In the past year, how many days (include half-days or partial days) did you miss work or usual daily activities due to illness or injury?
❑ None ❑ 1 Day ❑ 2 Days ❑ 3 Days ❑ 4-5 Days ❑ 6-10 Days ❑ More than 10 Days

7) I have had the following colon cancer screening exams:
❑ Finger Rectal Exam in the past year ❑ Home Testing Kit in the Last 2 Years that I used
❑ Stool exam in the last year at a clinic ❑ Sigmoidoscopy or colonoscopy in the last 5 years

8) **(Men only)** When was your last prostate exam (rectal exam and/or PSA blood test)?
❑ < 1 year ago ❑ 1-2 years ago ❑ 2-4 years ago ❑ 5+ years ago ❑ Never ❑ Don't Know

9) **(Women only)** Which preventative health screenings have you had ***in the last 12 months***?
❑ Pap Test ❑ Mammogram ❑ Breast Exam by a physician or nurse

10) **(Women only)** Are you currently pregnant? ❑ Yes ❑ No ❑ Unknown

STRESS

11) In the past year, how stressful has your life been?
❑ Not at all stressful ❑ Slightly stressful ❑ Somewhat stressful ❑ Quite stressful ❑ Extremely stressful

12) How effective are you at dealing with the stress in your life?
❑ Not at all ❑ Slightly effective ❑ Somewhat effective ❑ Quite effective ❑ Extremely effective

13) Do you have close friends or family that you can talk to and count on for support? ❑ Yes ❑ No

14) How many hours of sleep do you generally get a night? ❑ <5 ❑ 5-6 ❑ 6-7 ❑ 7-8 ❑ 8+

15) How often do you feel depressed? ❑ Most of the time ❑ Some of the time ❑ Rarely ❑ Never

16) Currently, how would you rate your mental health overall? ❑ Excellent ❑ Good ❑ Average/Fair ❑ Below Average ❑ Poor

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TOBACCO USE

17) Do you smoke? ❑ I have never smoked ❑ I used to smoke but quit ❑ Yes, I smoke currently

18) On the average, I smoke this many cigarettes per day:

❑ I don't smoke ❑ <1 ❑ 1-9 ❑ 10-14 ❑ 15-19 ❑ 20-29 ❑ 30-39 ❑ 40-49 ❑ 50+

19) **(Non-smokers Only)** On a typical day, are you in the presence of other people who are smoking? ❑ Yes ❑ No

DIET

20) In the past 12 months, have you attempted to lose weight? ❑ Yes ❑ No

21) If yes, were you successful in meeting your goal(s)? ❑ Yes ❑ No ❑ N/A

22) Do you take a multivitamin or supplement 5 days or more per week? ❑ Yes ❑ No

23) Compared to 5 years ago, I weigh: ❑ Less ❑ Same ❑ Gained 1-10 lbs ❑ Gained 11-20 lbs ❑ Gained 20+ lbs

RECENT HEALTH CARE

24) Have you had a scheduled exam/appointment with a physician in the past 12 months? ❑ Yes ❑ No

25) In the past 12 months, have you been hospitalized overnight? ❑ Yes ❑ No

26) In the past 12 months, have you sought care at an emergency room? ❑ Yes ❑ No

27) In the past 12 months, have you sought care at an urgent care or immediate care clinic? ❑ Yes ❑ No

28) Do you take 2 or more prescription medications? ❑ Yes ❑ No

29) Are you aware of the side effects of your prescription medications? ❑ Yes ❑ No ❑ N/A

30) My last **general physical exam** was: ❑ < 12 months ago ❑ 1-2 years ago ❑ 2-3 years ago ❑ 3-4 years ago ❑ 5+ years ago

31) My last visit to a dentist was: ❑ < 12 months ago ❑ 1-2 years ago ❑ 2-3 years ago ❑ 3-4 years ago ❑ 5+ years ago

32) My last eye exam was: ❑ < 12 months ago ❑ 1-2 years ago ❑ 2-3 years ago ❑ 3-4 years ago ❑ 5+ years ago

EXERCISE

33) How many days a week (on average) do you get 30+ minutes of continuous moderate intensity physical activity?
(for example, walking at a moderate pace) ❑ 7 Days ❑ 5-6 Days ❑ 3-4 Days ❑ 2 Days ❑ 1 Day ❑ None

34) How many days a week (on average) do you get 20+ minutes of continuous vigorous exercise?
(for example, jogging, swimming, briskly walking) ❑ 5+ Days ❑ 4 Days ❑ 3 Days ❑ 2 Days ❑ 1 Day ❑ None

35) When you have health concerns, do you have a specific physician from whom you seek medical care? ❑ Yes ❑ No

If yes, physician's name:_____in _____(city)

Thank you. All personal health information is strictly confidential.
Please present this completed form at your Health & Wellness Assessment.